



Children's speech and language services

Eastern Metropolitan Region Department of Human Services

Stage 1 Project Report
August 2004

Children's speech and language services

Eastern Metropolitan Region

Department of Human Services

Stage 1 Project Report

August 2004

Published by Eastern Metropolitan Regional Office,
Victorian Government Department of Human Services
Melbourne Victoria
August 2004

© Copyright State of Victoria, Department of Human Services, 2004

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

Authorised by the State Government of Victoria, 555 Collins Street, Melbourne.

Printed by Big Print, 520 Collins Street, Melbourne.

This document may also be downloaded from the Department of Human Services web site at: www.dha.vic.gov.au/emr

ISBN: 0731162110

Contents

Foreword	v
Summary of recommended actions	vi
1 Introduction	1
1.1 Purpose of the project	1
1.2 Project Reference Group	2
1.3 Methodology	2
2 Childhood speech and language development and problems	4
2.1 Speech, language and communication	4
2.2 Childhood speech and language development	4
2.3 Speech and language problems in childhood	4
2.4 How many children have speech and language problems?	5
2.5 What problems can co-exist with speech and language problems?	5
2.6 Consequences of childhood speech and language problems	6
2.7 What does available evidence on intervention tell us?	6
3 Current services in Eastern Metropolitan Region	7
3.1 Introduction	7
3.2 Universal services	7
3.3 Statewide paediatric speech pathology services	10
3.4 Services for children with additional needs	10
3.5 Private speech pathologists	14
3.6 How current services operate	15
4 Major needs as perceived by services	20
4.1 Demand and waiting times	20
4.2 Inequitable access to Community Health Services	20
4.3 Earlier identification and referral	20
4.4 Variety of intake points and processes	20
4.5 Earlier services	21
4.6 Priority needs	21
4.7 Recruitment	21
4.8 Service practice and service system issues	22
5 Government policy context	23
5.1 <i>Children First</i> policy (2003)	23
5.2 <i>Future directions for the Victorian Maternal and Child Health Service</i> (2004)	23
5.3 <i>Early Childhood Intervention Services vision and priorities</i> (2004)	24
5.4 Best Start and Neighbourhood Renewal	24
5.5 <i>Community Health Services – creating a healthier Victoria</i> (2004)	25
5.6 Department of Human Services' objectives and priority actions 2003-04	26
5.7 Major themes of Victorian Government policy	26
5.8 <i>Towards the development of a national agenda for early childhood</i> (2004)	26
6 Conclusions and recommendations	27
6.1 Introduction	27
6.2 Building service system capacity	27
6.3 Improved demand management and coordination	35
6.4 Implementation Process	43
7 Action plan	41
Appendices	44
Appendix 1 – Project terms of reference	44
Appendix 2 – Community Health Service catchment maps	45
Appendix 3 – Results of the Discussion Paper forum	47
Appendix 4 – Bibliography	50

Foreword

There is now widespread recognition of the importance of early childhood and its effects on health, learning and behaviour in the later stages of development.

There is also increasing will to improve coordination of services for children and families so that efforts can be integrated around optimising development and learning.

A critical part of development and learning is communication.

Most children acquire speech, language and communication skills without extra assistance, but some experience problems that require action, including attention by a speech pathologist.

The Eastern Metropolitan Regional Office (EMR) of the Department of Human Services has established a project to examine current service delivery in this important area and work with services to identify what improvements might be made to assist to optimise children's learning and development.

This report outlines the results of the first stage of this project, and contains a number of recommendations that will be pursued as current and future resources permit.



John Leatherland
Regional Director
Eastern Metropolitan Region

Summary of recommended actions

Strategies		Recommended actions (refer to report for full recommendations)	Timeframe
Build service system capacity:	In community health	<p>Increase paediatric speech pathology in local Community Health Services (CHSs) in the medium term.</p> <p>Create child allied health teams in local CHSs in the medium term.</p> <p>Cover Upwey area through Maroondah Hospital.</p> <p>Eastern Health to explore additional/off-site services.</p>	<p>2004-05 plus</p> <p>2005-06 plus</p> <p>By December 2004</p> <p>By June 2005</p>
	In Specialist Children's Services (SCS)	Increase paediatric speech pathology in SCS in the medium term.	2004-05 plus
	Across speech pathology services	Consider service quality improvement project.	2005-06 plus
	Across generic services	Improve speech and language information and training to generic service partners.	2004-05 plus
	Through easier recruitment	Address recruitment issue/ explore shared positions.	2005-06 plus
Improve demand management and coordination through:	Better data/improving referrals	<p>Data collection and analysis in SCS and CHSs. Examine existing referral more closely and develop further strategies for earlier identification. Improve communication about roles and referrals. Explore common/complementary intake and referral between Early Childhood Intervention Services (ECIS) and CHSs.</p>	<p>2004-05 subject to project funding</p> <p>2004-05</p> <p>2004-05 subject to project funding</p>
	Earlier assessment	All CHSs and SCS to separate initial assessment from therapy.	2004-05 subject to project funding
	Adopting targets for assessment and therapy	Consider adopting targets for initial assessment and therapy in SCS and CHSs.	2005-06
	Transparent priority access	Ensure access for children with feeding and swallowing disorders.	2004-05
		Work on criteria for priority access in CHSs and SCS.	2004-05 subject to project funding
	Improving services while waiting	Organise consistent information and support while waiting.	2004-05 subject to project funding
	Clarifying role in assessing for school	Clarify appropriate role for under school age services in speech pathology assessments for school.	2004-05

1 Introduction

1.1 Purpose of the project

Parents are vitally concerned about their children talking.

Learning to communicate is essential for a child's general learning and development.

Conversely, speech and language problems can hamper a child's general development.

Unresolved and unaddressed, speech and language problems can significantly impact on the life of children and their families, and can contribute to more severe problems later in life. Intervention at the earliest appropriate stage has the best outcome.

Parents and extended family and friends, children's services and health services all have vital parts to play in supporting children to reach their maximum potential in speech, language and communication.

Speech pathologists play a particular role in the assessment and treatment of speech and language problems. Speech pathology can be delivered to children and families directly by the Victorian Department of Human Services through Specialist Children's Services (SCS), by agencies that receive State Government funding (Early Childhood Intervention Services (ECIS), community health centres and hospitals, and by private practitioners.

Demand from families for publicly funded speech pathology services is high and waiting times are typically lengthy.

Given the importance of early intervention to address speech and language problems, and the likelihood that demand for publicly funded speech pathology services will continue to be greater than supply, the Department of Human Services Eastern Metropolitan Region (EMR) is undertaking a project on children's speech and language services.

This report covers Stage 1 of the project, which aimed to document the current service system and to see what strategies beyond those currently in place might ensure that those children and families most in need receive a timely response. The terms of reference of the first stage of the project are at Attachment 1.

Section 7 of this report is an action plan for the staged implementation of recommendations.

1.2 Project Reference Group

A reference group assisted Stage 1 of the project and comprised the following members:

- Ms Shauna Walter, Manager, Housing Primary and Complex Care, EMR (Chair)
- Ms Clare McGlone, Chief Executive Officer, MonashLink Community Health Service
- Ms Sharon Pretty, Speech Pathologist, Eastern Access Community Health
- Ms Lou Johns, Coordinator, Biala Box Hill Inc
- Ms Bernadette Fraraccio, Speech Pathologist, Irabina
- Ms Miralde Bartlett, Maternal and Child Health Coordinator, Manningham City Council
- Ms Fiona Page, Chief Speech Pathologist, Maroondah Hospital
- Ms Suzy Bennett, Preschool Field Officer, Children's Services, Manningham City Council
- Ms Anne Chapman, Children's Service Resource and Development Officer, City of Knox
- Ms Kate Paterson, Manager, Health, EMR
- Mr Steve Ballard, Manager, Child and Family Services, EMR
- Ms Kathy Hope, Manager, Early Intervention Services, EMR
- Ms Jann Kirkland, Team Leader, Specialist Children's Services Outer East Team, EMR
- Mr Jeff Herd, Senior Project Officer, EMR.

1.3 Methodology

The project officer collected factual information and views on key issues and strategies from services relevant to addressing the speech and language problems of EMR children and families. Recent reports on this topic were considered and discussions held with key statewide agencies, such as La Trobe University and the Centre for Community Child Health at the Royal Children's Hospital.

Based on the information collected, the project officer prepared a discussion paper that was circulated to all interested parties and was the subject of a regional forum held on 8 June 2004 and attended by 42 people.

The discussion paper outlined the major needs as perceived by the service system and included 17 options for future action. The forum was an opportunity for interested parties to discuss the identified needs and options and to indicate the priority that should be attached to each option.

A list of attendees at, and results of, the forum are at Attachment 2. These results have informed this report.

The availability of useful client data varies widely depending on program arrangements. Available data from community health services (CHSs) and maternal and child health services (M&CHSs) have been considered. At present, there is no useful client data easily accessible for EMR ECIS, although this situation is being addressed through the inclusion of this program in a new Department of Human Services data system, currently under development.

In this context, much of the information about client numbers used in this report is based on the views of service staff.

It was not possible within the resources of Stage 1 of this project to undertake consultations with families. It is envisaged that this will be an important component of the implementation phase of the project.

The Stage 1 project brief focused on speech and language problems and their treatment by speech pathologists.

While this remains the focus of this report, speech and language development and prevention and promotion strategies have been considered to a limited degree.

The project focus on one discipline has also been commented upon. Current thinking on early intervention (broadly defined) includes the following perspective:

Although the contributions of multiple professional orientations continue to influence the delivery of early intervention services, current conceptualisations of the process of early childhood development underline the futility of attempting to divide the needs of young children into discrete boundaries...

The target groups addressed by early childhood intervention are heterogenous rather than homogenous with a great deal of variation in their composition...

at its best, early intervention should involve multi-disciplinary collaboration...¹

This perspective has influenced the design of future actions in relation to paediatric speech pathology.

¹ Centre for Community Child Health, Royal Children's Hospital Melbourne for the Department of Human Services *Best Start Evidence Base Project* December 2001 pages 36–37.

2 Childhood speech and language development, problems and interventions²

2.1 Speech, language and communication

Speech is the physical behaviour by which most people communicate.

Language is how we communicate our thoughts and ideas using a set of symbols. Languages are usually spoken, but can also be based on gestures, printed symbols or touch. Language includes understanding what others say (receptive language) and creating one's own messages (expressive language).

Languages are part of communication, which is the process of exchanging ideas or information.

2.2 Speech and language development in childhood

Communication development starts at birth.

Children are immersed in a world of language from birth and the infant and toddler years are crucial for children's speech and language and lay the foundations of literacy.

By the preschool years, most children are competent language users.

Language learning is effortless for most children, biologically programmed and acquired at the same rate and developmental sequence worldwide.

2.3 Speech and language problems in childhood

Childhood speech and language problems can occur in relation to:

- **speech** impairment – for example, impairment of sounds and slurring
- **language** impairment – for example, impairment of language production or comprehension, reading difficulties and literacy problems
- **voice** problems
- **fluency** problems – for example, stuttering
- **swallowing/feeding** problems – for example, neurological conditions such as cerebral palsy and structural conditions such as cleft palate.

Problems occur along a continuum of complexity:

- problems that resolve in time
- problems that don't resolve without intervention
- problems that may have an underlying cause, for example, a hearing problem or a cognitive problem
- problems that are part of a pattern of developmental delays or disabilities (in children aged 0–6, this phrase is used to express uncertainty around whether some problems will persist, or are permanent).

2 Section 2 is based primarily on the following material: Centre for Community Child Health, 'Universal language promotion in the primary care setting' 2002 (unpublished).

Department of Human Services, *Communication, language and play: A universal language promotion strategy for 0–5 year olds*, 2004.

Department of Human Services 'Defining a regional framework for speech pathology services in the Northern Metropolitan Region Final Draft', July 2002 (unpublished).

People Care Australia for the Department of Human Services, 'Speech and language services in the Northern Metropolitan Region Final Draft' September 2000 (unpublished).

Sure Start Unit, British Government *Sure Start - promoting speech and language development- guidance for Sure Start programmes*, 2001.

2.4 How many children have speech and language problems?

There is no agreed figure on the overall prevalence of speech and language problems in children aged 0–6 years. Estimates vary according to how problems are defined and the methodology used.

Individual differences among children make it difficult to distinguish between normal variation and delays in development, passing difficulties and enduring impairments.

According to the Centre for Community Child Health, language delay is the most common single difficulty in preschool years. Fifteen to 20 per cent of children are late talkers at two years of age; up to two thirds of these children will be delayed at age three and one third (around 5 per cent) are still delayed at age four.

Language delay in some children resolves with time; others will have continuing subtle language and literacy problems, while others will suffer lifelong language impairment.

We currently don't know how to identify those children who have persistent language problems as compared with those whose problems resolve in time. This is a key issue for publicly funded primary health services, creating significant challenges in assessing the need for intervention and defining priorities for access to treatment.

The Royal Children's Hospital is leading a major five-year research project on the question of how to identify children who have persistent language problems, entitled the Early Language in Victoria Study (ELVS).

The ELVS aims to:

- learn how language develops in 1,800 babies from eight months up till four years of age
- tell us what helps good language development
- show what makes language more difficult for some children
- find out what might lead to earlier help for children with language problems.

Children from Maroondah and Whitehorse local government areas (LGAs) are part of the group being studied.

Current evidence also suggests that 5–8 per cent of 4–5 year-old children have developmental impairments of speech and language.

For the purposes of this project, a conservative figure of 6 per cent prevalence of specific speech and language problems has been chosen in relation to the 2–6 year-old group (which relates to the target group of CHSs). Children with speech and language problems as part of a pattern of developmental delays/disabilities (the target group of ECIS) are not included in this figure.

2.5 What problems can co-exist with speech and language problems?

Problems commonly occurring alongside specific speech and language problems include hearing and behaviour.

Behaviour problems can be triggered or exacerbated by a range of speech and language problems, including frustrated communication and language comprehension problems.

Sometimes helping behaviour problems leads to improved communication, and vice versa.

For speech and language problems that are part of a pattern of developmental delays/disabilities, related problems can include hearing, behaviour, cognition, intellectual disabilities and physical disabilities.

2.6 Consequences of childhood speech and language problems

The consequences of infant specific speech and language problems have been well established through longitudinal studies into childhood, adolescence and adulthood.

Language delay during the preschool years is associated with a range of negative outcomes in later childhood, particularly literacy problems, which have significant impacts on academic achievement and later employment opportunities.

There are robust associations between language delay and psychiatric/behavioural problems, social adjustment problems and delinquency.

Children and adolescents with language impairment are also at increased risk of emotional problems, such as social withdrawal, solitariness, loneliness and anxiety.

2.7 What does available evidence on interventions tell us?

Evidence suggests that early intervention is the key to producing a positive impact on developmental outcomes such as language development.

It is much more difficult to re-direct than it is to prevent negative effects from occurring in the first place.

Research suggests that prevention may be more effective than remediation because the neural networks and patterns of an infant's brain are 'sculpted' by the early social and physical experiences of the child.

Evidence indicates that universal early literacy promotion activities enhance early language development. Universal early language promotion strategies are highly likely to enhance early language development but have been less well studied.

Targeted prevention programs enhance language development in young children with early language delays.

For specific speech and language problems there is evidence of increased effectiveness where these problems are identified early in their course. There is strong evidence that children with language impairment respond to appropriate intervention in infancy and the preschool period. Evidence from a variety of studies indicates that treatment by speech pathologists helps, as do parent administered therapy and training programs.

Treatment by speech pathologists has been shown to help children with each of these kinds of difficulties:

- Treatment for expressive language difficulties in preschool children can produce significant positive results – this is true for treatment given by speech pathologists, parent-administered treatment and for those families offered a parent training program.
- Treatment for comprehension difficulties has been found to have positive results.
- Treatment for moderately severe speech sound difficulties is effective when given by speech pathologists.

While the state of evidence for particular speech pathology interventions is improving, many questions are still unanswered. In this context, speech pathologists need to combine their experience, judgement, the consensus of peers, and knowledge of evidence in practice decisions.

3 Current services in Eastern Metropolitan Region

3.1 Introduction

A wide array of services and resources in EMR are relevant to childhood speech and language development and problems, including:

- Universal services, such as:
 - child care
 - kindergarten/preschool
 - primary care services such as general practitioners, M&CHSs and CHSs.
- Services/resources for children with additional needs, including:
 - children's services resource and development officers and Playworks
 - preschool inclusion support services, for example, preschool field officers (PSFOs) and Special Education Program – Preschool Component
 - ECIS, such as SCSs and funded local government and non-government agencies.

3.2 Universal services

This section briefly describes the current role of the following universal government-funded services in responding to children's speech and language needs: child care and preschool services, M&CHSs and CHSs.

3.2.1 Child care and preschool services

Child care services provide care and developmentally appropriate programs for children from birth to the end of their primary school years. A range of child care options is available to meet the different needs of parents. The Commonwealth Government, through the Department of Family and Community Services, funds the Child Care Program, which has the objective to assist families with dependent children to participate in the workforce and the general community by supporting the provision of affordable, quality child care.

The Victorian Government, through the Department of Human Services, licenses children's services and provides funding to eligible occasional care centres.

The Victorian Government also funds the Preschool Services Program, which provides funding towards one year of preschool for all eligible children, with the aim of furthering the child's social, emotional, physical, intellectual and language development prior to the commencement of primary school. Children are eligible to attend a funded preschool program if they turn four years of age on or before 30 April in the year of attendance.

At the time of writing, there were 551 licensed children's services in EMR, including 242 stand-alone preschools, 234 child care services and 75 long day care centres (which provide child care and preschool services). More than 11,000 children were enrolled in funded preschool services in EMR.

3.2.2 Maternal and child health services

The objective of the Maternal and Child Health Service (M&CHS) Program is to ensure that all families with children from birth to school entry have timely access to flexible, high quality, efficient and effective community-based M&CHSs. Universal services are complemented by enhanced services to ensure parents experiencing significant parenting difficulties, vulnerable families and families with children identified at risk of harm, in particular children up to 12 months of age, receive more intensive support.

M&CHSs support parents and offer information and advice regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning.

EMR M&CHSs are located in each of the seven LGAs. Funded services include 10 key age and stage visits for all children. Seven of these are in the first 12 months, followed by visits at 18 months, two years and 3.5 years.

General development, including language, is observed at all appropriate stages. M&CHSs play a key role in helping to identify and refer children with speech and language problems to appropriate services.

Participation by EMR families in the 10 visits follows a statewide pattern from around 100 per cent participating in the first home visit, reducing to an average of about 65 per cent attending the 18-month visit, 60 per cent attending the two years visit and 50 per cent participating in the 3.5 year visit.

3.2.3 Community health services

The aim of the Community Health Program is to provide primary care services that improve the physical, mental and social wellbeing of Victorians and to reduce the requirements for hospital and other specialist institutional services.

The target group of Community Health Program-funded services is defined in current program guidelines as:

All Victorians are eligible to access services funded through the Community Health Program and Community Health Services (CHSs) should not place restrictions on access based on geography or other criteria. However, CHSs should prioritise their services towards population groups and individuals who have chronic and complex health issues and who are in lower socio-economic groups.

The Community Health Program funds hours of allied health, counselling and nursing services and health promotion activities. Fees are charged on the basis of income, with the usual allied health session fee for a client with a concession card being \$6.50.

CHSs receive Community Health Program funds and also deliver a range of other primary health services. CHSs are either independent community health centres or units of larger health services, such as hospitals.

In EMR, eight agencies receive Community Health Program funding:

- seven locally-managed CHSs
- Eastern Health, which includes four sites receiving funding.

Each LGA has one CHS; the Shire of Yarra Ranges has two services:

- Ranges CHS, which has sites at Lilydale and Belgrave, and has the south-west part of the Shire as its catchment
- Yarra Valley CHS, which is part of Eastern Health, is sited at Healesville (a shopfront and part of the Healesville Hospital site) and Yarra Junction, and has the Yarra Valley as its catchment.

Five out of seven local CHSs and two out of four Eastern Health Community Health Program-funded sites currently provide paediatric speech pathology services.

Table 1 Paediatric speech pathology in EMR CHSs

EMR CHSs	Catchment	EFT*	Client nos in recent 12 mths**
Eastern Access Community Health	Maroondah, Knox***	0.7	153
Inner East	Boroondara	1.2	230
Knox	Knox	0	0
Manningham	Manningham	0.26	60
MonashLink	Monash	0.5	50
Ranges South west	Yarra Ranges	0	0
Whitehorse	Whitehorse	1.0	150
Eastern Health - Yarra Valley CHS	Yarra Valley	0.2	20****
Eastern Health - Maroondah Hospital site	Multiple LGAs	2.42	494
Eastern Health - Box Hill Hospital site	Multiple LGAs	0	0
Eastern Health - Angliss Hospital site	Multiple LGAs	0	0
Total		6.38	1157

* EFT means effective full-time.

** Estimates provided by staff.

*** This catchment was a condition of the funding allocation.
EACH's usual catchment for CHS is Maroondah.

**** Estimates as position being recruited to at present.

As shown in table 1, provision by EMR CHSs of paediatric speech pathology ranges from no EFT to 2.42 EFT at Eastern Health – Maroondah Hospital site.

The delivery sites and catchments of EMR Community Health Program-funded paediatric speech pathology services are depicted in Map 1 and Map 2 respectively in Appendix 2.

The history of services in EMR includes:

- Paediatric speech pathology and psychology positions at Whitehorse CHS and at EACH's Ringwood site were created by additional funding allocations following the closure of paediatric outpatient services at Box Hill Hospital in the mid-1990s.
- Manningham was originally serviced from Whitehorse CHS, but subsequently received an allocation to create a part-time position.
- The service at Boroondara CHS initially resulted from a transfer of resources and positions from Yarra.
- Some agencies have topped the original allocation of funds.
- The more recent creation of a part-time position at MonashLink CHS was a result of reallocation of existing resources.

That is, four of the services were initiated by specific allocations, with some being topped up by agency decisions, and the fifth by reallocation.

The current model of service at Eastern Health – Maroondah Hospital site, the Maroondah Approach to Clinical Services (MACS), was developed in 1992–93 in response to substantial and increasing waiting times. The catchment of this service is east of Springvale Road, north of Burwood Highway, south of the Yarra, and the NSW border. Within EMR, the catchment covers Maroondah and parts of Whitehorse, Knox, Yarra Ranges and Manningham (see Appendix 2, Map 2). It was drawn up in 1993, when Box Hill and Dandenong hospitals also had paediatric speech pathology services, which have since ceased.

3.3 Statewide paediatric speech pathology services

In addition to paediatric speech pathology services available within EMR health services, EMR families and children can access services in other locations, including:

- the Child Fluency Clinic and Voice Clinic operated by La Trobe Communication Clinic at La Trobe University, Bundoora
- a range of specialist outpatient clinics at the Royal Children's Hospital.

Information on the number of EMR families accessing these services is not readily available.

3.4 Services for children with additional needs

3.4.1 Children's services resource and development officers and Playworks

Children's services resource and development officers (CSRDOs) are Commonwealth Government funded positions based at each of the seven local councils in EMR. Their role includes to:

- promote and assist the development and adoption of inclusive practices in Commonwealth funded child care programs (including 0–6 and school age programs)
- work with child care services on specific inclusion strategies
- facilitate planning for the inclusion of children with additional needs
- enhance understanding of childhood development
- foster links between child care and other community services to facilitate better support and access for families.

CSRDOs play a key role in helping to identify and refer children who have speech and language problems to appropriate services.

The Commonwealth Government has flagged a role change for CSRDOs to be implemented in January 2006 following a tendering process in 2005. No other details are available at the time of writing.

Playworks, based in Armadale, is funded by the Commonwealth Government to support the development of inclusive Commonwealth-funded child care programs by providing resources, information and library support, newsletters and associated materials, training and referral to local CSRDOs. It is part of Noah's Ark (see 3.4.6 below).

3.4.2 Preschool field officers and the Special Education Program – Preschool Component

Preschool field officers (PSFOs) are positions funded under Preschool Inclusion Support Services to provide support to children with additional needs to access and participate in state-funded preschool programs through the provision of consultative support, resourcing and advice to preschool teachers and parents.

PSFOs assist preschool staff in the development of appropriate plans for individual children, and refer children where appropriate to services such as SCSs for more specialist assessment. PSFOs may also provide information to staff and families concerning other available resources and services.

In EMR, PSFO positions are attached to local councils, a community agency and the department.

The Special Education Program – Preschool Component, which includes both Commonwealth and state funding, offers supplementary funding for preschool initiatives to support the access and participation of children with severe disabilities and high support needs who are deemed eligible for the program.

3.4.3 Early childhood intervention services introduction

ECIS are funded by the Victorian Government through the Department of Human Services to provide special education, therapy, counselling, service planning and coordination, and assistance and support to access services such as preschool and child care to facilitate positive outcomes for children below school age with additional needs and their families.

The target group of ECIS is defined in current program guidelines as:

children, prior to school entry, with a disability or developmental delay, and their families who require a range of co-ordinated services and a level of support not usually available through universal services.

Three types of services are funded:

- SCS
- ECIS-funded agencies
- statewide resource agencies.

3.4.4 Specialist Children's Services

SCS in EMR comprise two multidisciplinary allied health teams and a central intake function (established in 2002). The two teams cover different catchments: the Inner East Team is based at Box Hill and covers the LGAs of Boroondara, Manningham, Whitehorse and Monash; the Outer East Team is based in Ringwood and covers the LGAs of Maroondah, Knox and Yarra Ranges. There are currently 1.8 EFT speech pathologists in the Inner East Team and two EFT speech pathologists in the Outer East Team.

Over a recent 12-month period, about 180 children were provided with service by the Inner East speech pathologists and about 200 children have been provided with service by the Outer East speech pathologists.

There is no charge for SCS.

3.4.5 ECIS-funded agencies

Sixteen services based in local governments, CHSs and non-government organisations located in EMR receive ECIS funding for 708 EMR children with development delay/disabilities. Some of these are large agencies with statewide catchments; others are local agencies. ECIS-funded agencies are funded for an agreed number of children. ECIS-funded agencies normally charge fees.

Staff teams typically include speech pathologists. The current provision of speech pathologists in these services is shown in Table 2.

Table 2 ECIS-funded agencies – number of current paediatric speech pathologists (PSPs) and other information, 2004

Agency name	Catchment*	No. of children funded*	Current PSP EFT
Biala Box Hill	Whitehorse	56	1.0
Cerebral Palsy Education Centre	EMR	31	0.8
Child and Family Care Network - Warooga	EMR	55	1.0
City of Knox - Illoura	Knox	76	1.67
EACH - Healesville	Yarra Ranges	31	0.2
EACH Maroondah	Maroondah	23	0.5
Irabina	EMR	124	3.0
Manningham CHS -Stride	Manningham	44	0.7
Mooroolbark	Maroondah/ Yarra Ranges	22	0.4
RVIB Eastern Region	EMR plus**	42	0.1
Scope - South Eastern Specialist Services	EMR	7	0.25
Shire of Yarra Ranges, Yarra Valley	Yarra Ranges	26	0.4
Taralye	EMR plus**	77	1.2
Villa Maria	EMR plus**	32	0.6
Yooralla Blackburn	EMR plus**	36	0.8
Yooralla - The Patch	Yarra Ranges	26	0.7
Total		708	13.32

* Catchments and numbers of children funded according to service agreements; actual catchments and numbers of children may vary.

** Numbers of children funded and EFT are estimates of EMR's portion of larger services.

3.4.6
ECIS-funded statewide resource agencies

Noah’s Ark is a statewide ECIS-funded agency that supports families that have children and young adults with additional needs. Noah’s Ark provides a wide range of services including toy and equipment borrowing and counselling and discussion groups for families. Noah’s Ark operates out of 18 locations across Victoria, including Ringwood.

The Communication Resource Centre (CRC) is a statewide service based in Box Hill, working for people with complex communication needs to create inclusive environments. The CRC plans and develops resources and provides web-based and telephone-based information and referral services, peer support, and training for families, staff and others who live and work with people with complex communication needs between 0-6 years or 18 years and over. The CRC is part of Scope, formerly the Spastic Society. Staff include speech pathologists and occupational therapists.

Co-located with the CRC are:

- Makaton Victoria, which provides workshops in the Makaton Vocabulary, which uses key word sign and gesture to support communication, and is a means of encouraging language development in children and adults with communication difficulties
- the Gastronomy Information and Support Society, for those with gastronomy tubes for temporary or permanent feeding
- CARM, the Communication Aids and Resource Materials Service, which designs and produces pictographic resource materials.

3.5
Private speech pathologists

According to publicly available information, there are 48 sites in EMR at which private speech pathologists offer services.

Table 3
Number of private speech pathology sites in EMR by LGA 2004*

LGA	No. of sites
Boroondara	13
Knox	6
Manningham	4
Maroondah	0
Monash	8
Whitehorse	12
Yarra Ranges	5
Total	48

* Information derived from 2004 Yellow Pages and Better Health Channel.

Many practitioners are part-time and 14 sites indicate they have a paediatric focus. Some practitioners work across the continuum of need and some work both in publicly funded services and private practices.

Available information on costs indicates that some practitioners charge \$90 to \$150 for initial assessments and \$70 to \$100 for 60 minutes (less for shorter periods). Speech pathology costs are covered under some private health insurance products, with costs usually capped at an annual limit.

3.6 How current services operate

3.6.1 Identification and referral

There is no generally accepted screening test for speech and language problems, unlike, for example, vision. In the absence of this, identification of problems falls to families and the range of health and children's services in contact with children aged 0-6 years.

As well as parents, the range of services that identify children with possible problems include:

- M&CHSs
- child care staff and CSRDOs
- preschool staff and PSFOs
- paediatricians
- general practitioners.

If children appear to have a speech and language problem only, these services will suggest attention by a speech pathologist. Options presented to parents include private speech pathologists or a publicly funded paediatric speech pathologist in a Community Health Program-funded service (which targets this group), where these are available. Long waiting times can discourage referrals to publicly funded services. Referral for a hearing test is common at either this point or following initial assessment by a speech pathologist.

Consulted services report that many families are unable to afford private speech pathology, while others consider that child speech and language problems are a government responsibility.

A referral will usually involve providing information to the parent who takes the next step. With the parent's permission, the referring agency may provide written information to the next service.

3.6.2 Paediatric speech pathology in community health services

The following information is based on interviews with the five local CHSs currently providing paediatric speech pathology (that is, excluding Maroondah Hospital, described below, and Yarra Valley CHS, not operating at the time of writing).

CHSs are part of the Primary Care Partnership service coordination reform, which includes the progressive adoption of standardised intake and referral tools and processes across a wide range of health and community services, making these steps easier for consumers and agencies. The electronic transfer of referral information is part of the reform. All CHSs are implementing service coordination tools and processes.

When families call CHSs for a speech pathology appointment, they will typically be asked for client information and advised of waiting times and local private speech pathology options. Average waiting times at the time of project interviews ranged from three months to up to 12 months. Some services close their books around June/July to children attending school in the following year, as they are unable to provide services to them.

M&CHSs were cited by two CHSs as their main referral source. Two of the five services have developed and use specific referral formats with their local M&CHS; one of these is a version of the Primary Care Partnership service coordination tool.

All services run a general wait-turn system; within this, three of the five services give some priority to certain categories of children. Three of the five services currently separate initial assessment from service and two have separate assessment and service lists.

Most clients have specific speech, language or fluency problems, and the average age of children when they are first seen peaks at four years.

Most service is provided in one-to-one sessions, with parents present, and is delivered in blocks (for example, 5–8 weeks on, 5–8 weeks off). Three out of five services operate or have operated groups in addition to one-to-one service.

Four of the five services undertake Department of Education required assessments for children going to school and requiring additional speech and language assistance.

Four of the five services have at least one other paediatric staff position, and undertake joint work or cross-referrals when appropriate.

3.6.3 Community Health Program-funded paediatric speech pathology at Maroondah Hospital

If families are located in the Maroondah Hospital Community Health Program-funded paediatric speech pathology service (the Maroondah service) catchment, they may be offered the option of a referral to that service. Eligibility is confirmed when parents contact the service.

The main referral sources to the Maroondah service are M&CHSs and preschool teachers.

The service aims for the longest time between referral and initial assessment to be two months, but this can increase to 3.5 months in peak times. Initial assessment is followed closely by service provision, which commences with parent training, and then parents and children access a therapy stream, which is usually a group.

Group, individual and home-based services are provided (51 per cent of clients receive one form of therapy). Assessment, parent education and group and individual services are provided in a building next to Maroondah Hospital.

Most clients have specific speech, language or fluency problems and, like other CHSs, the Maroondah service closes its books around June/July to children attending school in the following year.

Of the 494 children seen in 2003, 47 per cent came from the Shire of Yarra Ranges; 35 per cent came from Maroondah; 11 per cent came from Knox, 6 per cent came from Whitehorse, and 1 per cent came from Manningham. Sixty-eight per cent of clients travel less than 10 kilometres to the service. In an analysis of five years of client discharge questionnaires, 92 per cent of clients reported satisfaction with the service.

3.6.4 Speech pathology in Specialist Children's Services

Referral sources to SCS include hospitals, M&CHSs, paediatricians, CHSs, preschool teachers, CSRDOs, PSFOs and families.

A central intake service provides an initial response to families when they call. SCS sits alongside ECIS-funded agencies, and families choose between services. SCS can also act as a stepping-stone to ECIS-funded agencies. Beside speech pathology, disciplines include occupational therapy, physiotherapy, dietetics, social work, education and psychology.

Children with developmental delays and/or disabilities who require speech pathology include those with:

- global development delay
- autism spectrum disorder
- feeding and swallowing problems
- high medical needs
- Down's syndrome
- cerebral palsy.

SCS service models include joint assessments, one-to-one service provision, home visiting and group work. Practice is family-centred.

Waiting time for SCS speech pathology was between five and 10 months at the time of writing.

3.6.5 Coordination between Specialist Children's Services and Community Health Services

There is an undocumented understanding between SCS and CHSs that have paediatric speech pathology services that CHSs are focused on children with specific speech and language problems, while SCS are targeted at children with developmental delays and disabilities, which usually include speech and language problems.

There is also liaison between SCS and CHSs, particularly where the CHS has other paediatric allied health practitioners besides speech pathologists and they have some capacity to provide services to children who have speech and language and other, usually mild, needs.

3.6.6
ECIS-funded agencies service provision

Referral sources include SCS, paediatricians, hospitals, private allied health practitioners, CHSs, preschool teachers, CSRDOs and PSFOs.

Initial eligibility and screening usually occurs soon after contact by parents. Average waiting time for service ranges from immediate to up to 12 months. Information and interim support is usually offered to parents who are waiting for service.

Multidisciplinary staff teams undertake family-centred practice.

Service models are predominantly centre or group based, with one-to-one services sometimes available, and increasingly provide support to children and families in generic settings.

Seven services are provided by large ECIS/disability agencies; four services are provided by large community agencies (including two CHSs); three services are provided by local community-managed agencies; and local government provides two services. Some agencies have specialities, such as autism spectrum disorder, cerebral palsy, hearing impairment and vision impairment.

3.6.7
Current service capacity

At the time of project interviews, there were 23.5 EFT publicly funded paediatric speech pathologists in CHSs and ECIS in EMR. Over 12 months, it is estimated that 2,245 children would be receiving paediatric speech pathology services.

The numbers of EMR families accessing private speech pathology for their children is not known.

Table 4 Numbers of children provided with a CHS or SCS paediatric speech pathology service/ECIS-funded service over a recent 12-month period

Service	PSP EFT	Client nos over recent 12 mths	% of total number of children provided with service
CHS	6.38	1,157	51.5%
ECIS - SCS	3.8	380	17.0%
ECIS funded agencies	13.2	708	31.5%
Total	23.5	2,245	100%

3.6.8 Transition to school

Children can enrol in primary school if they turn five years of age by March of the year in which they start school. Children must attend school when they are six years of age.

The Department of Education and Training provides a range of resources to government schools to enable the delivery of a high quality program for all students, including students who are having difficulty learning. These resources may be provided in the school global budget, through other support services or through specific early identification and intervention programs.

Student support services include speech pathologists to address the speech and language needs of primary and secondary school students. In 2003, 16.8 EFT speech pathologists were part of student support services in EMR.

The Program for Students with Disabilities is an additional program that provides resources to schools to support the educational programs of students who meet the eligibility criteria, based on World Health Organization definitions of disabilities and designed to identify that group of students with more severe or profound disabilities.

The five criteria for severe language disorder includes a score of two or more standard deviations below the mean for the student's age in expressive and/or receptive language skills on two of the recommended tests, as assessed by a speech pathologist.

Evidence is obtainable from department student support services or parent held information that may include reports from ECIS, hospital paediatric services and speech pathologists.

Applications are due in the fourth term of the prior year. Applications for 2004 closed on 10 October 2003. Program guidelines indicate that a program support group has to be established to complete an application, consisting of the principal or their nominee, a classroom teacher, parents, students (as appropriate) and consultants that can include preschool teachers, ECIS staff, department staff and speech pathologists. Program guidelines envisage that there will be initial contact between parents and the principal, who is responsible for informing parents about the process and arranging for the necessary assessments to be carried out.

Children eligible for this program are usually clients of ECIS-funded services and, less often, SCS. In practice, many ECIS-funded agencies play active roles in the transition of children into school. There are varying approaches to the completion of assessments required by the Department of Education and Training. Some services don't undertake these assessments if they are additional to their usual requirements; others complete them with the stated aim to ensure access to support at the earliest possible time.

4 Major needs as perceived by services

This section outlines the major needs identified through interviews with agencies, grouped around general themes. This statement of needs is based on the informed opinion of service managers and practitioners. Important issues about which objective information is not readily available are included.

4.1 Demand from families for publicly funded speech pathology is high and waiting lists and times for speech pathology are typically long:

- This was raised unanimously by all interviewed agencies.
- Waiting times were problematic in relation to both CHSs and SCS.
- Many families can't afford private speech pathology and hardly any private speech pathology is available in the multidisciplinary setting required by families with children with multiple needs, or in group settings.

4.2 Some families and children have inequitable access to Community Health Program-funded paediatric speech pathology services because of their location:

- Families in the Upwey area lack access to Community Health Program-funded paediatric speech pathology provided by either CHSs or the Maroondah service.
- Families in Knox and the southwest part of the Shire of Yarra Ranges lack access to paediatric speech pathology services from their local CHS (Knox CHS and Ranges CHS respectively).
- Families in the Yarra Valley part of the Shire of Yarra Ranges have access to eight hours per week of local Community Health Program-funded paediatric speech pathology services.
- Families in Manningham have access to 10 hours per week of local Community Health Program-funded paediatric speech pathology services and limited access to the Maroondah service.
- Families in Monash have access to 19 hours per week of local Community Health Program-funded paediatric speech pathology services and no access to the Maroondah service.

4.3 Some families and children require earlier, accurate identification of additional needs and earlier referral:

- For many children, identification of additional needs at four years, usually through preschool, is not optimal and needs to be earlier.

4.4 Families and referring services face a variety of intake points and processes:

- Different services have their own intake points and processes – there is no easy way for families and referring services into public speech pathology services.
- Families initially referred to a CHS and assessed by the CHS as needing SCS, have to re-wait for services (although some families may only be ready to agree to a referral for specific speech and language problems, when a referral to SCS would be more appropriate in the opinion of the referring service).

4.5 Families and children who have a referral require earlier services:

- Families with children attending four-year-old preschool who are identified as having additional needs, face missing out on services before attending school because of long wait times.
- Long waiting times for service represent missed opportunities for children and parents, and significantly increase parental anxiety.

4.6 Some families and children have priority needs that require an improved response:

- Variations in family readiness and capacity need to be accommodated in service delivery models. Sometimes parents have needs that require attention before they can become an effective partner in pursuing improvements in their child's speech and language development.
- Families with babies and young children with early feeding/swallowing problems do not always receive a timely response from SCS.
- Agencies are not always equipped to provide appropriate services for babies/children with swallowing and feeding problems and cerebral palsy, and children with autism.
- Families with babies identified at birth as having a disability don't always receive timely multidisciplinary intervention.
- Children with complex communication needs who wait for service and effective communication aids can experience negative effects on all their learning and development.
- Families with children with mild speech needs, who on assessment have other mild needs, would benefit from multidisciplinary services from CHSs and participation in appropriate, inclusive children's services, but these are not widely available.

4.7 EMR services can experience problems in recruiting to paediatric speech services:

- Some CHSs have experienced significant difficulties in recruiting to their paediatric speech pathology positions.
- Increasing difficulties in attracting experienced staff are expected.

4.8 Service practice and service system issues:

- Many services are not collecting and analysing usable data about clients, service quality and outcomes, thereby limiting their capacity to base improvements on objective information, and hampering their efforts to communicate their work to external stakeholders.
- While some coordination efforts occur on a program or area basis, the current array of services are mainly uncoordinated, making family access more difficult and making keeping up with service changes a laborious task for agencies.
- Communication about eligibility and feedback on referrals is inadequate across the service system.
- Speech pathologists face high demand pressure and focus their time on direct service delivery, leaving limited internal capacity for service system development.
- Allied health assistant positions to speech pathologists are rare but there are many tasks they could undertake under the direction of a speech pathologist.
- There is a polarity of views about one-to-one service models and group models. Some favour a one-to-one model and view groups as a less desirable service model driven by resource scarcity. Others favour groups as an efficient method of addressing common needs in a setting that parents and children are comfortable with, and consider that the current service system is imbalanced towards one-to-one services for which there is little evidence. Others see a place for both one-to-one and group services, while also noting that the current system is imbalanced towards one-to-one services.
- There is some confusion about who is responsible for speech pathology assessments required by the Department of Education and Training for eligible children commencing school to access additional resources under the Program for Students with Disabilities.
- The development of effective, individualised, non-electronic communication aids is time-consuming and requires a combination of specialist design expertise and practical aid-making skills that are not widely available.

5 Government policy context

Victorian Government and Commonwealth Government policy for children, families and health includes a range of directions and opportunities for future actions on childhood speech and language development and problems.

Work is underway to develop a Victorian early childhood policy framework.

5.1 *Children First policy (2003)*

The Victorian Government's *Children First* policy articulates a commitment to continue to invest in early childhood services. It highlights the need to link universal and secondary early childhood services to better identify children at risk and to improve outcomes for children and their families. It recognises the importance of early identification of risk factors and the provision of timely and appropriate intervention. It also includes new ways in which to build, strengthen and connect services, including maternal and child health, maternity, early intervention, kindergarten, child care and family support services.

Additional funding and new initiatives under the *Children First* policy include:

- \$8 million over four years of capital funds for 30 integrated children's centres from 2003–04
- \$16 million over four years of additional funding for M&CHSs from 2003–04
- \$1 million over four years for additional professional development of maternal and child health nurses from 2003–04
- \$8 million capital grants for new preschools from 2003–04
- \$6 million over four years for early childhood intervention services from 2003–04
- establishment of a Victorian Children's Advisory Committee to advise the Premier on the development of an integrated whole of government Victorian Children's Services Strategy.

5.2 *Future directions for the Victorian Maternal and Child Health Service (2004)*

The vision of the M&CHS is:

All Victorian children and their families will have the opportunity to optimise their health, development and wellbeing during the period of a child's life from birth to school age.

The M&CH mission is:

To engage with all families in Victoria with children from birth to school age, to take into account their strengths and vulnerabilities, and to provide timely contact and ongoing primary health care in order to improve their health, development and well-being.

Critical success factors for M&CHSs in the future will be:

- universal access and participation for all children from birth to school age and their families
- a focus on the prevention, promotion, early detection and intervention of health and wellbeing concerns of children
- provision of services for children and families, recognising a diversity of need
- partnerships with families, communities, service providers and state and local governments
- local planning, flexibility and collaboration
- support to provide a quality service.

Current statewide initiatives in the M&CHS include:

- additional state funding to strengthen the capacity of M&CHSs, including increasing participation of families in the 18-month, two years and 3.5 year visits, and flexible service capacity
- \$1 million for training
- resources to support the development by local government of Municipal Early Years Plans in 2004
- development of a universal language promotion strategy for 0-5 year-olds, including resource kits for M&CHSs.

5.3 Early Childhood Intervention Services vision and priorities (2003)

The Victorian Government's *Early Childhood Intervention Services vision and priorities* includes:

- the goal that ECIS are part of a comprehensive and integrated continuum of child and family services that supports all children and families
- parents as partners to promote the development and early learning of their child
- the understanding that children with a disability or developmental delay and their families have the same core needs as other children and families – these needs can be addressed by universal services such as maternal and child health, playgroups, family services, child care and preschool
- developing more effective linkages with universal services, such as maternal and child health, general practitioners and preschools, to promote early identification and referral of children in need of specialised assessment and support
- providing support that complements the knowledge and skills of staff in universal services
- strengthening the focus of prevention across the whole early childhood infrastructure and the development of a shared understanding across health, education and care professions with regard to family and child wellbeing.

Another statewide initiative in ECIS is the establishment and funding of a three-year Autism Secondary Consultation and Training Strategy, delivered through the Centre for Developmental Psychiatry and Psychology at Monash University. This strategy will improve the provision of training, information and resources, community development and secondary consultation to support staff delivering services for children with autism spectrum disorder aged 0-6 years and their families. An initial contact number is 9905 1553; a website is under development and will be linked to www.ecis.vic.gov.au.

5.4 Best Start and Neighbourhood Renewal

The Best Start initiative, jointly auspiced by the Department of Human Services and the Department of Education and Training, aims to:

- improve the social, emotional and physical wellbeing of children (0-8 years)
- improve the capacity and competency of parents and carers
- assist communities to become more child friendly.

The underlying strategy for Best Start is the development of an accessible, coordinated and flexible universal service platform, with a focus on families that may not currently access services. To date, 11 Best Start projects have commenced activity in high needs areas across the state.

In EMR, a Best Start project is operating in the Shire of Yarra Ranges, initially focused in the Upper Yarra area. Strategies chosen by local services and families include:

- increased education and support to enable parents to maximise speech and language development of their children, including through increased utilisation of the 3.5 year-old M&CHS visit and increased funding for speech therapy services
- increased children's exposure to literature and early learning experiences.

Neighbourhood Renewal is an initiative of the Office of Housing that has introduced a new approach in the way government and agencies relate to and provide services to communities. This approach will:

- empower local communities to shape their own futures
- develop a shared vision for neighbourhoods through local Neighbourhood Renewal action plans and achieve this vision through the efforts of the whole of government that will be coordinated around people and the places they live, work and play
- create vibrant places where people want to live.

Locations have been selected because of their relative disadvantage compared to other parts of Victoria and are generally where there are concentrations of public housing.

In EMR, a Neighbourhood Renewal project is operating in Ashburton, Ashwood and Chadstone.

5.5 Community Health Services – creating a healthier Victoria (Public Consultation draft)

The Department of Human Services' *Community Health Services – creating a healthier Victoria Public Consultation* draft:

- notes that CHSs are significant providers to families and children through allied health (for example, speech therapy), health promotion and, increasingly, dental health services (other key groups are people on low incomes and older people)
- notes that Victoria's CHSs are one part of an infrastructure that offers the opportunity to achieve improved outcomes for children and families through building a stronger, more inclusive and comprehensive universal service platform
- envisages that by the end of the decade, CHSs will:
 - provide leadership in improving the health outcomes and reducing health inequalities of local communities throughout Victoria
 - be the major platform for delivering a comprehensive range of integrated primary health care services that promote health and prevent illness
 - provide high quality, affordable and timely primary health care to people with the poorest health status and greatest economic and social need for services.

5.6 The Department of Human Services' objectives and priority actions 2003–04

The department's objectives and 2003–04 priority actions include:

- **building sustainable, well managed and efficient human services**
 - working in partnership with the funded sector
 - increasing service capacity
- **providing timely and accessible human services**
 - managing demand for services
 - joining up services to improve the continuity of care
- **improving human service safety and quality**
 - planning and managing for better service quality
 - investing in training and development
- **promoting least intrusive human service options**
 - improving outcomes through prevention, screening and early intervention
- **strengthening the capacity of individuals, families and communities**
 - promoting health and wellbeing
 - enhancing child development and wellbeing
- **reducing inequalities in health and wellbeing**
 - targeting the needs of specific communities.

5.7 Major themes of Victorian Government policy

In summary, the key themes of current Victorian Government policy include:

- the evidence base for early intervention
- strengthening support to families
- parents as partners in child development
- accessible and integrated services
- additional needs services linked to universal services
- coordinated initiatives to reduce disadvantage in partnership with higher needs communities
- CHSs' potential role in improved outcomes for children and families
- Early Childhood Policy Framework under development.

5.8 *Towards the development of a national agenda for early childhood (2004)*

At the Commonwealth level, work is also being undertaken to develop a national agenda for early childhood, including the following suggested principles:

- a focus on prevention and early intervention
- attention to risks that emerge in early childhood and in the development of responses to protect against risk and build resilience
- a universal approach encompassing all children, with a focus on vulnerable communities, families and children
- maximising collaboration
- inclusion of children with differing abilities.

6 Conclusions and recommendations

6.1. Introduction

The Department of Human Services Eastern Metropolitan Regional Office considers that a new approach to addressing the needs of families with children with speech and language problems is needed.

This approach should build on the considerable strengths of the current set of services, including their:

- clear commitment to doing the best for families within available scarce resources
- level of expertise in providing high quality services
- cooperation in working together locally and developing a continuum of services to match the differing needs of families and children
- strong interest in supporting children and families in their natural settings.

The problem of a gap between demand and supply of publicly funded paediatric speech pathology services is widespread and occurs in most jurisdictions in Australia and overseas. It is expected that demand for publicly-funded paediatric speech pathology will remain high.

Multiple strategies are, therefore, required to achieve improvements for families and children with speech and language problems and to ensure that those children and families most in need receive a timely service, through:

- building service system capacity
- improving demand management and coordination.

Resources available for implementation of recommendations can include:

- existing service, management, training and development resources
- future opportunities for additional recurrent funding or reallocation of existing resources
- one-off funding from EMR (subject to program priorities)
- in-kind resources from funded agencies
- opportunities to link up with resources from research and statewide agencies.

Staged implementation is envisaged.

Implementation stage 1 involves:

- recommendations that can be implemented, or implementation commenced, in the immediate to short-term, defined as over the next six months or so, using existing resources
- recommendations that can be implemented over the next 12 months or so (2004–05), subject to the availability of additional funds.

Implementation stage 2 involves:

- recommendations that can be implemented over the following 12 months or so (2005–06), either using existing resources or subject to the availability of additional funds.

6.2 Building service system capacity

6.2.1 Increased paediatric speech pathology in local community health services in the medium term

For the purposes of this project, a conservative figure of 6 per cent prevalence of specific speech and language problems in relation to the 2-6 year-old group has been chosen.

Some recommendations span both of these stages.

As implementation stage 1 proceeds, new understandings and opportunities are likely to arise that will require modification of current plans.

This category of problems relates to the target group of CHSs, but not the ECIS target group.

This figure can be used as an indicator of potential need. It is noted that need can vary from demand, which can be indicated by numbers being provided with a service and waiting for service, and waiting times, and can include appropriate and inappropriate referrals. Demand and need can also be hidden, for example, referrals not made because of absence of service or long waiting times.

Table 5 Select EMR population data, estimated resident population at June 2001

LGA	Population	2-6 year olds	% 2-6 yrs of total	6% of 2-6 year olds
Boroondara	157,214	8,774	5.6%	526
Knox	147,433	10,515	7.1%	631
Manningham	113,893	6,161	5.4%	370
Maroondah	100,279	6,735	6.7%	404
Monash	163,141	8,229	5.0%	494
Whitehorse	147,085	8,382	5.7%	503
Yarra Ranges	142,553	10,436	7.3%	626
EMR total	971,598	52,232	5.4%	3,554

It is estimated that EMR CHSs saw 1,157 children with specific speech and language problems in a recent 12-month period. This represents about 33 per cent of 2-6 year-olds (at June 2001).

That is, the existing capacity of EMR CHSs relates to one-third of the potential need for services.

As stated above, it is not known how many EMR families are accessing private speech pathology.

In addition, there is no agreed benchmark against which to evaluate this level of publicly funded service capacity.

What is clearer is that the current level of need that is addressed by CHSs varies significantly with the presence and amount of speech pathology in local CHSs, and whether families live in the current catchment of the Maroondah service.

In consultations with agencies and at the forum, the option to increase the supply of paediatric speech pathology in local CHSs in the future was deemed the top priority.

CHSs with one EFT or more of paediatric speech pathology – Whitehorse CHS and Inner East CHS – are making a significant local contribution to addressing the speech and language needs of children in their catchment.

CHSs with less than one EFT – EACH, Manningham, Monash and Yarra Valley – are still making a contribution to addressing local need, but appear to be facing greater problems in relation to waiting times and, in some instances, local service coordination and other non-direct service delivery functions. That is, these services lack critical mass. Families in Maroondah and the Yarra Valley can access the Maroondah service but only a small part of Manningham is eligible, and Monash is not covered.

Two local CHSs are without any paediatric speech pathology – Knox CHS and Ranges CHS.

Families in Knox can access the 0.7 speech pathologist at EACH, and those living north of the Burwood Highway can access the Maroondah service.

Families in the Ranges catchment – the southwest of the Shire of Yarra Ranges – can access the Maroondah service if they live north of the Burwood Highway.

Families in the Upwey area, which is south of the highway, are not currently able to access Community Health Program-funded paediatric speech pathology in EMR.

On the basis of available information, the level of local need addressed by CHSs appears to be relatively low, particularly for families in the cities of Monash, Knox and Manningham.

Given the importance of early intervention, the consequences of unaddressed speech and language problems in later life, and the benefits to families of accessing local services, there is a case to increase the amount of paediatric speech pathology in local CHSs.

Realisation of this aim could involve a number of courses of action.

One involves the reallocation of existing Community Health Program funding at the discretion of individual CHSs. CHSs typically face strong demand for most allied health services currently being offered, and reducing the level of service offered in one area to create or increase service in another area can raise significant issues.

At the same time, families with children are a critical part of the Community Health Program target group and therefore have a claim on available services, and draft policy directions include the opportunity for CHSs to strengthen their contribution to child health and wellbeing. At least one local CHS has created a part-time service through reallocation.

Recommendation 1:

That the department and local CHSs in EMR adopt an aim to increase the availability of locally provided paediatric speech pathology services.

Reallocation can involve creation of additional services in paediatric speech pathology following a vacancy and/or allocating hours from an existing position focused on adults to children, provided that the practitioner is appropriately skilled. Proposals to reallocate hours from other paediatric disciplines to speech pathology would require close consideration, given support indicated below for the creation of child allied health teams in local CHSs.

Reallocation should be examined by each local CHS and the results reported to the department by December 2004.

Where reallocation is not appropriate, another course of action is the allocation, though future budgets, of additional recurrent funding which could be used for this purpose (either because funds are targeted to children, or EMR has some discretion over the purpose).

Families in Monash, Manningham and Knox have relatively lower access to available services than families in the other LGAs, and this needs to be addressed. At the same time, there is a case for aiming for a stronger local capacity in all catchments in EMR that is accessible to families and able to be integrated with other children's services. All CHSs should consider making a clear priority of paediatric speech pathology.

Achieving the aim to increase the availability of locally provided paediatric speech pathology services will take some time.

Recommendation 2:

That the Department of Human Services EMR and local CHSs define and adopt a benchmark for local paediatric speech pathology to be achieved in the medium term.

Recommendation 3:

That local CHSs examine opportunities for reallocation and advise the department.

6.2.2 Adjustment of the Maroondah Hospital Community Health Program-funded speech pathology service catchment

The Maroondah service is a sub-regional service that uses 38 per cent of the current EMR EFT staff capacity to provide services to 42 per cent of the currently serviced client group. This major service operates at the higher end of the existing range of client throughput: staff ratios.

The service is primarily provided at one centre, with families travelling to it (68 per cent travel less than 10 kilometres), and it is understood that current resources are tightly scheduled to meet existing referred demand in the current catchment.

The Maroondah service operates an approach to organising clinical services that has attracted international and interstate interest and adoption following training provided by Maroondah staff. In particular, the approach includes a focus on group work for children with similar problems and their parents.

As noted above, the current catchment was drawn up in 1993 and since then relevant surrounding hospital-based outpatient services have ceased and some local community health services have been created.

The most critical gap in regional coverage by Community Health Program-funded services is the Upwey area, which lacks access to either locally-based services or the Maroondah service. This requires immediate action.

Recommendation 4:

That the Maroondah Hospital Community Health Program-funded paediatric speech pathology service immediately extends its catchment to include the whole of the Shire of Yarra Ranges, and advises local referral services.

Recommendation 5:

That Eastern Health examines opportunities to reallocate existing Community Health Program resources to paediatric speech pathology and advises the department.

Recommendation 6:

That the department and Eastern Health examine the options of the Maroondah service increasing its provision of services off-site.

Recommendation 7:

That EMR advocates to the central office of the department for the creation of consistent child allied health teams within local CHSs.

The Maroondah service covers all the rest of the Shire of Yarra Ranges; extending the current catchment to cover this area is recommended. It is acknowledged that this will increase demand on the Maroondah service. As a potential indicator of increased demand, around 50 2-6 year-olds (or 6 per cent) who live in this area might be expected to have speech and language problems.

At the Discussion Paper forum this option was not universally supported, with concerns expressed about the difficulties some families would have travelling to Ringwood. This is acknowledged, however, extending the Maroondah service catchment is the most viable option for immediate action.

6.2.3 Examining options to build service system capacity through Eastern Health's Community Health Program

In the same way that local CHSs are being asked to consider reallocation of existing resources to the priority area of paediatric speech pathology, it is reasonable to request that Eastern Health undertake a similar examination in relation to its Community Health Program funding.

Options for future service provision within Eastern Health include the Maroondah service increasing its off-site provision. At present, most families who use the Maroondah service are from: the Shire of Yarra Ranges, who otherwise have access to only limited local services in the north-eastern part of the Shire; and the City of Maroondah, who also have access to the local service at EACH in Ringwood.

In the medium term, an improved service system for families across EMR could involve increased local services and improved access to MACS. Improved access to MACS implies an increase in the number of its service delivery sites. The Maroondah Hospital has advised that the Maroondah services' current resources are tightly scheduled to meet existing referred demand in the current catchment. The costs and benefits of increased service provision off-site would need to be closely examined in light of the requirement to maintain the viability of the Maroondah service.

6.2.4 Consideration of the establishment of child allied health teams in local Community Health Services

In the course of examining paediatric speech pathology services in local CHSs, the presence of other paediatric allied health practitioners – psychologists, occupational therapists and physiotherapists – in some CHSs was noted. Again, these positions appear to have been created by either particular allocations or through agency decisions. Many agencies consulted felt strongly that action on paediatric speech pathology in CHSs should be accompanied by action on other allied health services required by children. Forum participants considered the option to create child health teams in local CHSs the fourth highest priority option.

Other forum participants noted that this topic was outside the terms of the project. While that is so, the strength of views about this direction, the interaction between behaviour and speech and language problems, and the concept that at its best, early intervention should involve multidisciplinary collaboration, suggests that EMR should at least raise this need with the central office of the department. Some CHSs have also advocated for the creation or enhancement of teams that have core disciplines and best practice models of service defined on a consistent statewide basis.

6.2.5 Increased paediatric speech pathology in EMR Specialist Children's Services in the medium term

Demand on paediatric speech pathology services is also high – measured in wait-times – in relation to available services within SCS. (In general, children wait for a package of services in ECIS-funded agencies, and wait-times are not specific to speech pathology.)

At the forum, participants indicated that the option of increasing service capacity in EMR SCS was the third top priority.

The current 3.8 EFT in EMR SCS appears to be low (EMR's estimated population at June 2001 was 971,598) when compared to 6.4 EFT paediatric speech pathologists in SCS in the former Northern Metropolitan Region (population of 766,801) and 7.6 EFT paediatric speech pathologists in SCS in Southern Metropolitan Region (population of 1,119,813).³

Given the importance of early intervention and the relatively high and complex needs of the SCS target group, there is a strong case for adopting the aim of increasing paediatric speech pathology service capacity in SCS in the medium term.

In ways similar to CHSs, opportunities to realise this aim include internal reallocation and/or additional recurrent funding. The allocation of future ECIS growth funds to SCS will require the agreement of ECIS-funded agencies.

Recommendation 8:

That in the medium term, EMR Specialist Children's Services should aim to increase their effective full-time speech pathology positions.

6.2.6 Improving the capacity of service partners

A wide range of services for children and families are a vital part of the environment in which children develop. M&CHSs, child care services and CSRDOs, and preschool services and PSFOs are critical components of this environment.

M&CHSs support parents and offer information and advice regarding child health and development, including language. Nurses offer counselling on issues and have key roles in identifying needs that require a referral to another service.

The roles of child care services and CSRDOs and preschool services and PSFOs encompass:

- optimising children's language experiences
- helping to prevent problems
- identifying and referring children with problems
- providing inclusive environments for children with identified speech and other problems.

In the course of this project, agencies reported significant scope to improve the information and/or training available to M&CHSs, child care staff and CSRDOs, and preschool staff and PSFOs to optimise their roles as partners in pursuing improvements in children's speech and language development, in identifying problems and making appropriate referrals, and in supporting parents.

³ Information provided by SCS EMR in March 2004.

A 2004 initiative to support M&CHSs by the department and the Centre for Community Child Health at the Royal Children's Hospital is 'Communication, language and play – A universal language promotion strategy for 0–5 year-olds'. This strategy includes a kit, which comprises:

- a five-page fact sheet for health professionals on language promotion in the early years, which covers definitions, language delay, universal language promotion, techniques for parents, an outline of what to expect of normal communication development and some potential areas of concern and additional reading
- communication, language and play bookmarks and information sheets to give to parents at their regular age and stage visits from two weeks to 4–5 years
- a statewide resource sheet
- a local resource sheet to be filled in.

The strategy kit has been distributed to all M&CHSs and the Centre for Community Child Health delivered a presentation on the kit at a recent statewide forum.

The Project Reference Group considered this to be an excellent resource, suggesting possibilities for further training of EMR M&CHSs and the need to consider producing adaptations of the kit for other children's services. *The Future directions for the Victorian Maternal and Child Health Service* (Department of Human Services, 2004) notes that this program resource 'will be relevant for use by a range of services for children and families' (page 19).

Initial options to resource additional training to EMR M&CHSs in the strategy include using a portion of one-off funds available to assist in the implementation of the *Future directions for the Victorian Maternal and Child Health Service*.

A statewide training needs analysis is planned for M&CHSs to guide the best use of the \$1.0 million allocated in the 2003–04 State Budget for M&CHSs training. EMR M&CHSs should consider raising communication, speech and language training needs as part of this process.

CSRDOs are another speech and language service partner with information and training needs regarding speech and language development. Playworks, funded by the Commonwealth Government as a resource for child care services and CSRDOs, has expressed interest in the development of resources to promote language-rich children's services, and possible adaptation of the communication, language and play kit.

Preschools and PSFOs are the third service partner considered in this project. The current access of PSFOs to high quality, consistent information and support resources concerning speech and language development and problems is variable, and this should be addressed. Options for resourcing a small project in EMR to develop high quality information resources includes accessing a grant from a current pool of one-off resources for ECIS training.

As EMR's situation is potentially similar on a statewide basis, another option is for the department's central office to sponsor a larger, more comprehensive project across service partners. This would not preclude interim action by EMR, as a statewide project would necessarily involve a longer lead-time. A more comprehensive project would address problem identification and strategies for children's services staff and parents, as well as language promotion.

Recommendation 9:

That high quality speech and language information and training be provided to EMR M&CHSs, PSFOs and preschool staff and CSRDOs and child care staff.

Recommendation 10:

That the department's central office considers the development of an information resource on speech and language development, problems and strategies for staff and parents for use across children's services.

Recommendation 11:

That additional training in the Communication, language and play kit be delivered to EMR M&CHSs.

Recommendation 12:

That interim information and training be provided to EMR PSFOs.

Recommendation 13:

That an EMR quality improvement project for paediatric speech pathology services be considered for resourcing as part of Stage 2 implementation.

Recommendation 14:

That recruitment and retention issues be considered for attention as part of Stage 2 implementation.

6.2.7 Strengthening existing paediatric speech pathology services

Options suggested by agencies to pursue improvements to the quality of, and support available to, existing paediatric speech pathology services included:

- developing arrangements for accessing speech pathology expertise in specialised areas, for example, cerebral palsy, possibly using the Speech Pathology Australia mentoring model
- resourcing a senior clinician leadership role to support EMR practitioners and help address their training and development needs
- supporting a regional network of paediatric speech pathologists and creating an ongoing training and development program around key questions facing paediatric speech pathology, including the issue of the best use of group work and the measurement of service quality and outcomes.

While these options received reasonable support at the Discussion Paper forum, a number of other options to improve the front end of services and to provide services to parents while waiting were deemed higher priorities.

There is also logic in addressing front-end matters first, together with pursuing increases in paediatric speech pathology, and then further considering how best to pursue quality improvements in a more capable and organised set of services.

6.2.8 Recruitment and retention

Difficulties in recruiting and retaining paediatric speech pathologists have been experienced by some EMR agencies, and it is likely that difficulties will increase over time, given predicted national shortfalls across early childhood services and the attractions of private practice. While EMR may have limited capacity to affect this, consideration could be given to options such as shared positions between agencies. Given other priorities, this issue is recommended for greater attention in Stage 2 implementation, although agencies are encouraged to pursue options such as shared positions from the outset.

6.3 Improved demand management and coordination

6.3.1 Improved communication about roles and referrals

While most services considered that the number of inappropriate referrals were relatively low, issues were reported in relation to keeping up-to-date with roles and service capacity and lack of feedback on referrals.

Instances of good local referral relationships between local CHSs and M&CHSs, based on regular communication, were cited. In at least two LGA catchments, CHSs and M&CHSs have developed agreed formats for referrals, one linked to the Primary Care Partnership service coordination system. One catchment reported a shift to earlier age referrals as a result of good service relationships.

Recommendation 15:

All services should endeavour to ensure that they minimise their number of inappropriate referrals, including working with major referral sources.

Recommendation 16:

That SCS and CHSs establish a communication protocol about respective roles, referrals and feedback on referrals.

A key service relationship requiring improved communication arrangements is that between SCS and CHSs. Current coordination is mainly on an informal basis and clearer, more consistent arrangements would be created if a formal protocol was developed. Such a protocol would encompass written clarification of roles, arrangements for referrals and feedback on referrals between these two services.

These matters are considered to be good current practice, able to be achieved within current resources.

6.3.2 Identification and referral at the earliest appropriate age

It was a strongly held view amongst services that many children should be identified and referred for assessment earlier than four years of age. Referral within the preschool year also involves long waiting times, with the consequence that children may only be seen briefly before attending school.

Available data from CHSs indicates a peak of children at four years, although many of these would have been waiting a number of months before being seen.

It has not been possible for this project to collect detailed information about existing referral patterns, accepted and non-accepted clients, and services provided to clients.

More detailed objective information is needed to inform the development of region-wide earlier referral strategies. Information about referrals, clients and services provided will also provide a baseline against which to monitor changes arising from this project generally. A process that collected common data across SCS and CHSs for a period of two to three months is suggested. This should form one component of a Stage 1 service improvement project.

This region-wide step should not preclude local CHSs and M&CHSs from local planning to achieve earlier accurate identification and referral.

6.3.3 Common/complementary intake and referral processes

CHSs, SCS and ECIS-funded agencies have in the past all had individual intake and referral processes, presenting families and referring agencies with a confusing diversity of intake points and processes.

As part of the Primary Care Partnership reform, CHSs and other public health services are adopting common formats and processes for initial contact, needs identification and referral. Software and hardware developments to enable electronic referral between agencies are also underway.

In relation to SCS and ECIS-funded agencies, EMR is undertaking a project regarding a common intake system for these services. A departmental client data system applicable to SCS and ECIS-funded agencies is also under development.

These developments need to be considered together at the regional level and options for common, or at least complementary, intake and referral processes identified and examined.

Families can face waiting for service twice if they were referred to a CHS but a referral to SCS would have been more appropriate. The option of SCS accepting the initial date of referral to a CHS, so the family is not disadvantaged by the initial inappropriate referral, should be examined as part of the examination of options for common/complementary intake and referral processes.

6.3.4 Information and support for families while waiting

Many services, notably ECIS-funded agencies, provide a range of information and support to families waiting for a service. Such provision should be part of the approach of all services, and opportunities to offer information and support on a cross-service, coordinated basis should be considered.

All families waiting for a service (in CHSs, SCS and ECIS-funded agencies) should receive information about the service for which they are waiting, the service system, general developmental information, common language, communication and behavioural problems and initial strategies, where appropriate. All families waiting for a service should be offered opportunities to link with other families in similar circumstances.

6.3.5 Separation of initial assessment from therapy

SCS and four out of six CHP-funded services operate a service delivery system whereby initial assessment and service are separated.

There is a strong case for separating initial assessment from service across all relevant services:

- at present, high needs children and families can wait the same time as lower needs children and families
- inappropriate referrals can be referred on more quickly
- active waiting list management becomes possible if family and child need is known
- parental anxiety can be lessened to some degree
- where appropriate, initial specific information and support can be given to parents.

In addition, consistent best practice service delivery arrangements for initial assessment should be developed and adopted. This would include approaches to initial assessment and later assessment that are common across CHSs and, if appropriate, SCS.

6.3.6 Priority access

All agencies undertake some degree of priority setting for access to service, or interim support, although in most instances this is undertaken at a less formal level within a wait-turn system.

The issue of priority setting is complex.

Some agencies have argued strongly for a balance of service provision between children with more moderate needs who can be effectively assisted, and children with more complex needs.

Evidence about the consequences of specific speech and language impairment, which suggests moderate problems that are unresolved can have serious consequences in later life, supports this view.

It is generally agreed that children with swallowing and feeding problems at risk of aspiration or poor health are a clear priority for early service, usually SCS.

The issue of other criteria for priority access, such as high family stress, age of child and family history of speech and language problems, should be further considered by Department of Human Services program management, SCS and CHSs.

Because of their different target groups, it is expected that CHSs and SCS will have separate priority frameworks.

Recommendation 17:

That the department resource a Stage 1 service improvement project to undertake:

- *collection and analysis of objective knowledge of current referrals, accepted clients and services provided in CHSs and SCS*
- *examination of options for common/complementary intake and referral processes between CHSs and SCS*
- *development of information and support for families*
- *the separation of initial assessment from therapy in all CHSs, and the development of common arrangements for this in all CHSs and SCS*
- *development of priority access frameworks for CHSs and SCS*
- *consultation with parents as part of the project.*

6.3.7 Consultation with parents

Consultation with parents is an important component of designing effective service improvements and should be undertaken as part of the Stage 1 service improvement project.

6.3.8 Adopting targets for initial assessment

There are a number of examples of speech pathology services successfully adopting targets for initial assessment and services. The Maroondah Hospital's MACS was developed in response to substantial and increasing waiting lists and has successfully reduced waiting times for assessment and therapy.

Another example is the area health service in the Hunter Region of New South Wales, which established a Speech Pathology Access Project in 2001–02 to address average waiting times for assessment of 12 months or more for paediatric non-inpatient speech pathology services spread over 18 sites in community health and hospital settings. Two existing models – one being the MACS – were considered and utilised.

An average waiting time of less than six weeks was achieved. Strategies adopted by services included:

- the allocation of sufficient assessment appointments each month to keep pace with the referral rate
- the development of a staffing roster or client referral system to other services, which addressed any mismatch of local resources to conduct assessments
- the expanded use of targeted group interventions and home programs, where clinically indicated.

The typical speech pathology site in the area health service comprised two to three practitioners, which appears to more easily enable the adoption of group work and is in contrast to current services in EMR.

Nonetheless, the adoption of targets for initial assessment should be considered in Stage 2 implementation. Individual agencies are encouraged to explore earlier adoption.

6.3.9 Babies and children with feeding and swallowing problems

In discussions of priority access and service system coordination, babies and children with feeding and swallowing problems were considered a high priority for attention.

Two issues in particular were raised:

- Coordination between hospitals and SCS in EMR regarding these children currently occurs on an informal basis, and clearer, more consistent arrangements would be created if a formal protocol was developed.
- While these children are appropriately accorded a high priority for access to SCS, their complexity of needs and relatively low numbers requires a proactive approach by SCS to ensure its practitioners maintain up-to-date knowledge and skills.

A statewide protocol between public maternity services and M&CHSs is currently under development; the development of arrangements between hospitals and specialist children's services on babies and children with feeding and swallowing problems should take account of this.

Recommendation 18:

That the adoption of targets for initial assessment should be considered in Stage 2 implementation.

Recommendation 19:

That EMR M&CHSs, SCS and hospitals have clear arrangements for babies and children with feeding and swallowing problems, and that SCS maintains its skill base in relation to this group.

Recommendation 20:

That EMR advocate to the central office of the department for the design and provision of non-technological aids to be eligible for funding under the Aids and Equipment Program.

Recommendation 21:

That the Department of Human Services EMR clarifies the appropriate role of department-funded services for under school aged children in undertaking assessments for school purposes and advises funded services.

Recommendation 22:

That CHSs, SCS, ECIS-funded agencies, M&CHSs, PSFOs, CSRDOs and other interested parties be informed of progress on implementing recommendations as appropriate and in December 2004, June 2005 and June 2006.

Recommendation 23:

That the department establish an internal steering committee to coordinate, monitor and report back on action taken in relation to the action plan.

6.3.10 Communication aid development

Communication aids for children fall into electronic (high-technological/low-technological) and non-technological categories.

Some ECIS agencies raised the issue of resourcing to purchase the design and making of non-technological communication books.

While non-technological, these books can be highly sophisticated and often require a high degree of expertise to design, using software such as 'Boardmaker'. At present, this task can fall to inexperienced speech pathologists who can spend significant numbers of hours on it.

As an alternative, agencies suggested that a pool of resources could be made available so that speech pathologists could tap expert time, either for advice or for design.

Electronic aids are currently eligible for funding from the Aids and Equipment Program of up to \$4,500 per child under school age. As non-technological aids are more suitable for some children, the software and/or design and making of these aids should also be eligible for funding.

6.3.11 Speech pathology assessments for school

There is some confusion in the 0-6 year service system about responsibility to undertake particular speech pathology assessments required by the Department of Education and Training for children commencing school to access additional resources under the Program for Students with Disabilities in a timely way.

6.4 Implementation process

A range of actions are proposed in this report for implementation, either within existing resources or subject to additional resources being made available. Some of the key recommendations envisage ongoing action to achieve results in the medium term.

There has been a high level of interest and contribution in this project from EMR CHSs, SCS, ECIS-funded agencies, M&CHSs, PSFOs and CSRDOs through participation in interviews and discussions, representation on the Stage 1 Project Reference Group and attendance at the Discussion Paper forum.

There should be regular reporting back to all of these services of progress made on the recommendations.

Implementation will require ongoing attention by the department and others.

An internal steering committee should be established immediately to coordinate, monitor and report back on action taken under the action plan outlined in section 7 of this report.

The proposed service improvement project, which is subject to additional resources, should be guided by a widely representative project reference group.

Other actions will link with existing coordination structures. The need for new or modified coordination mechanisms should be monitored by the department's internal steering committee.

7 Action plan

Recommendations	Parties involved	Lead/coordinating responsibility	Resource implications with service	Timelines	Indicator report back
1: That the department and local CHSs in EMR adopt an aim to increase the availability of locally provided paediatric speech pathology services.	Manager, Health, EMR. CEOs, EMR CHSs.	Manager, Health, EMR.	CHSs to examine opportunities for reallocation. Where reallocation is not appropriate, speech pathology as a regional priority for future additional recurrent funding allocations.	1 and 2: by December 2004.	Documented agreement re aim, benchmark and intended timelines by December 2004.
2: That the department and local CHSs define and adopt a benchmark for local paediatric speech pathology to be achieved in the medium term.					Reports on initial examination of reallocation opportunities by December 2004.
3: That local CHSs examine opportunities for reallocation and advise the department.				3: an initial report by each CHS to the department by December 2004.	Progree reports June 2005 and June 2006.
4: That the Maroondah Hospital paediatric speech pathology service immediately extends its catchment to include the whole of the Shire of Yarra Ranges, and advises local referral services.	Manager, Health, EMR. Management, Eastern Health. Chief Speech Pathologist, Maroondah Hospital.	Manager, Health, EMR.	Within existing resources.	By December 2004.	Documentation of implementation reported in December 2004.
5: That Eastern Health examines opportunities for reallocation and advises the department.	Management, Eastern Health Manager, Health, EMR. Chief Speech Pathologist, Maroondah Hospital.	Manager, Health, EMR.	Within existing resources.	By June 2005.	Report results of examination and any proposals arising from examination in June 2005.
6: That the department and Eastern Health examine the options of the Maroondah service increasing its provision of services off-site.					
7: That EMR advocates to the central office of the department for the creation of consistent child allied health teams within local CHSs.	Manager, Housing Primary and Complex Care (HP&CC) EMR. Manager, Health, EMR. Central management.	Manager, Health, EMR.	Advocacy for future resources.	Ongoing	Reoprt initial action in December 2004, and subsequent action in June 2005 and June 2006.
8: That in the medium term, EMR specialist children's services aim to increase their effective full-time speech pathology positions.	Manager, Child and Family Services (C&FS), EMR. Manager, Early Intervention Services (EIS), EMR.	Manager, C&FS, EMR.	The department to examine opportunities for reallocation. Consideration of SCS speech pathology as a regional priority for future additional ECIS recurrent funding.	Initial examination by December 2004.	Report initial action and progress in December 2004 and subsequent action and progress in June 2005 and June 2006.

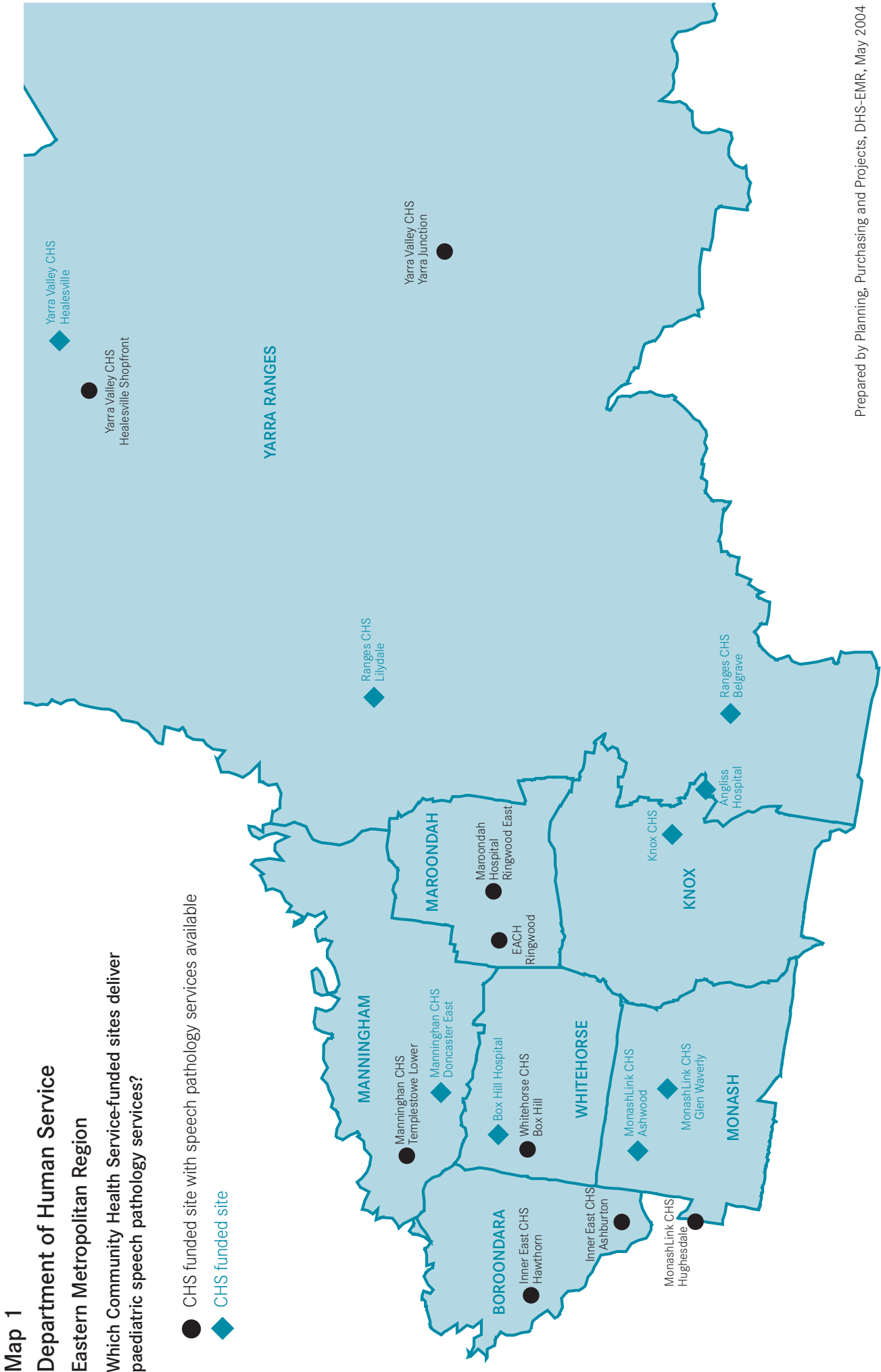
Recommendations	Parties involved	Lead/coordinating responsibility	Resource implications with service	Timelines	Indicator report back
9: That high quality speech and language information and training be provided to EMR M&CHSs, PSFOs and preschool staff and CSRDOs and child care staff.	Manager, C&FS, EMR. Management and staff, M&CH, PSFOs, CSRDOs. Commonwealth program management of CSRDOs.	Manager, C&FS, EMR.	Consideration of accessing current and future EMR and statewide training funds in M&CHSs and ECIS (for PSFOs).	Subject to future resource /training allocations.	Report progress in December 2004, June 2005 and June 2006.
10: That the central office of the department considers the development of an information resource on speech and language development, problems and strategies for staff and parents for use across children's services			Training for M&CHSs should be considered as one priority for current New Directions implementation funding in EMR and for the statewide training budget.		
11: That additional training in the communication, language and play kit be delivered to EMR M&CHSs.			Resources and training for PSFO's should be considered for current ECIS training funding.		
12: That interim information and training be provided to EMR PSFOs.					
13: That an EMR quality improvement project for paediatric speech pathology services be considered for resourcing as part of Stage 2 implementation	EMR Managers (HP&CC, C&FS, Health, EIS), SCS and CHSs.	Manager, HP&CC, EMR.	Requires one-off project funding and appointment of project officer.	Proposed for Stage 2 - 2005-06	Not applicable
14: That recruitment and retention issues be considered for attention as part of stage 2 implementation.	EMR Managers (HP&CC, C&FS, Health, EIS), SCS and CHSs.	Manager, HP&CC, EMR.	Within existing resources.	Proposed for Stage 2 - 2005-06	Not applicable
15: That SCS and local CHSs endeavour to ensure that they minimise their number of inappropriate referrals, including working with major referral sources.	Manager, EIS, EMR. CEOs, EMR CHSs	Manager, EIS, EMR.	Within existing resources.	Ongoing	Report in December 2004, June 2005 and June 2006.
16: That SCS and local CHSs establish a communication protocol about respective roles, referrals and feedback on referrals.	Manager, EIS. Manager, Health. CEOs, EMR CHSs.	Manager, EIS, EMR.	Within existing resources.	Initial meeting by November 2004.	Report in December 2004, June 2005 and June 2006.

Recommendations	Parties involved	Lead/coordinating responsibility	Resource implications with service	Timelines	Indicator report back
<p>17: That the department resource a Stage 1 service improvement project to undertake:</p> <ul style="list-style-type: none"> • collection and analysis of objective knowledge of current referrals, accepted clients, and services provided in CHSs and SCS • examination of options for common/complementary intake and referral processes between CHSs and SCS • development of information and support for families • the separation of initial assessment from therapy in all CHSs, and the development of common arrangements for this in all CHSs and SCS • development of priority access frameworks for CHSs and SCS • consultation with parents as part of the project. 	EMR Managers (HP&CC, C&FS, Health, EIS), SCS and CHSs. SCS/funded ECIS and CHSs. SCS/ funded ECIS and CHSs. CHSs and SCS. CHSs and SCS.	Manager, HP&CC, EMR. Widely-representative reference group to be established.	Requires one-off project funding and appointment of project officer.	Subject to funding	Report progress in December 2004, June 2005 and June 2006.
18: That the adoption of targets for initial assessment be considered in Stage 2 implementation.	EMR Managers (HP&CC, C&FS, Health, EIS).	Manager, HP&CC, EMR.	Not applicable.	Proposed for Stage 2 - 2005-06	Report progress as appropriate.
19: That M&CHSs, SCS and hospitals have clear arrangements for children with feeding and swallowing problems, and that SCS maintains its skill base in relation to this group.	Manager, EIS, EMR. SCS. Managers, M&CHSs. Eastern Health. Other relevant hospitals.	Manager, EIS, EMR.	Within existing resources.	To be completed by December 2004	Documentation of arrangements and skills plan to be reported by December 2004.
20: That EMR advocates to the central office of the department for the design and provision of non-technological communication aid to be eligible for funding under the Aids and Equipment Program.	Manager, EIS, EMR.	Manager, EIS, EMR.	Not applicable.	Ongoing.	Report progress as appropriate.
21: That EMR clarifies the appropriate role of the department-funded services for under school-aged children in undertaking assessments for school purposes and advises funded services.	Manager, C&FS, EMR. Manager, EIS, EMR. Manager, Health, EMR. Regional Management, Department of Education and Training.	Manager, C&FS, EMR.	Within existing resources. Role clarification may lead to reduced role.	Advice to services by December 2004.	Report in December 2004.
22: That CHSs, SCS, funded ECIS, M&CHSs, PSFOs and CSRDOs be informed of progress on implementing recommendations as appropriate and in December 2004, June 2005 and June 2006.	EMR Managers (HP&CC, C&FS, Health, EIS).	Manager, HP&CC, EMR.	Within existing resources.	December 2004. June 2005. June 2006.	Reports completed and forwarded.
23. That the department establishes an internal steering committee to coordinate, monitor and report back on action taken under this action plan.	EMR Managers (HP&CC, C&FS, Health, EIS).	Manager, HP&CC, EMR.	Within existing resources.	Immediately.	Report in December 2004.

Appendix 1: Project terms of reference

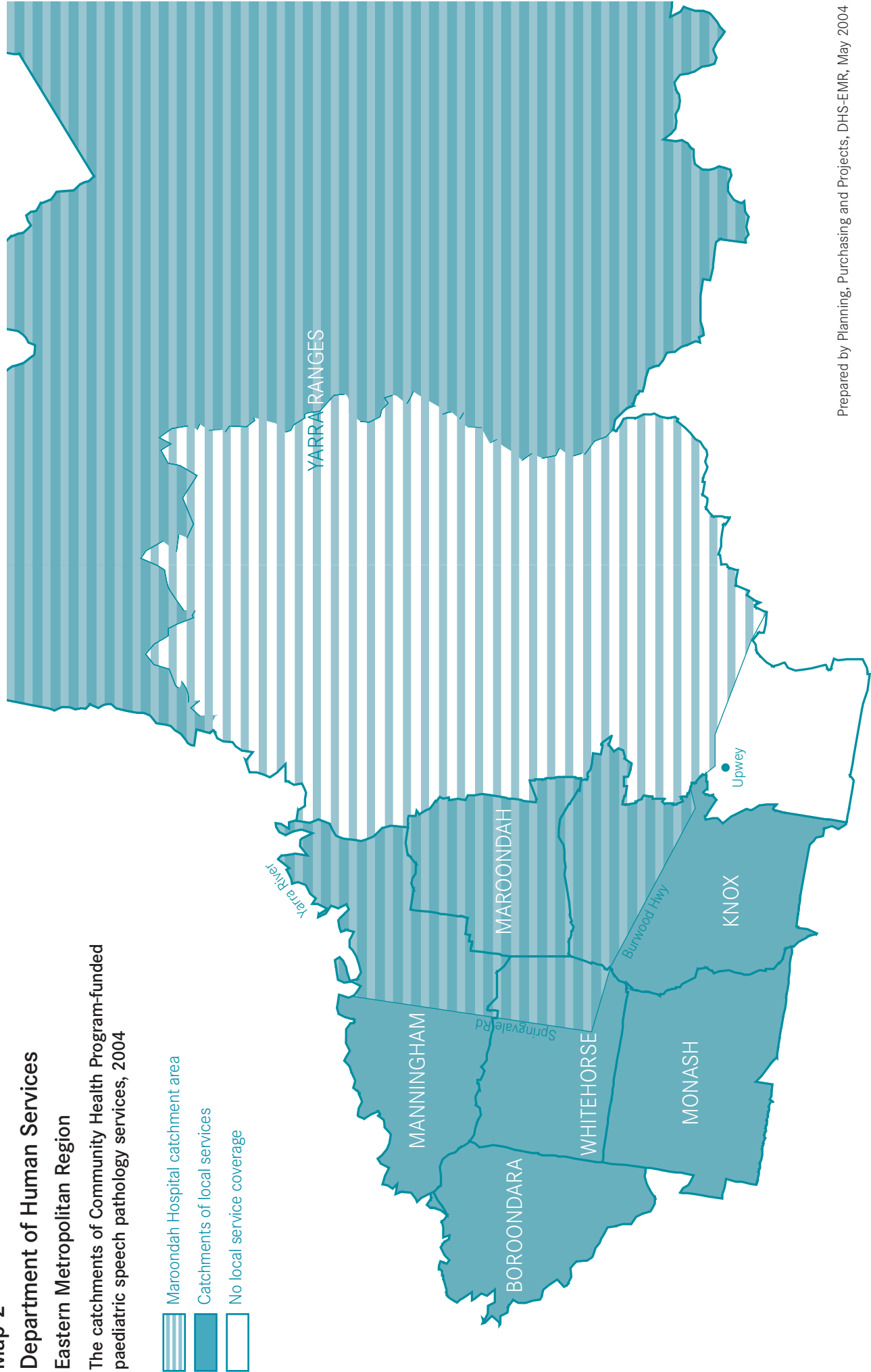
- 1 Document the current service system in EMR for speech pathology for children aged 0 to 6 years, including:
 - role, location, catchment, scale, funding source and eligibility
 - demand, waiting lists and times, priority-setting arrangements, services while waiting
 - key characteristics of child and families seeking and receiving services and service outcomes, including families from culturally and linguistically diverse backgrounds
 - service models and mix of models
 - major pathways to and through services, including referral sources
 - systemic characteristics including relationships between services and any gaps between services
 - current strategies to ensure well-targeted and effective service outcomes.
- 2 Explore what additional strategies might be adopted to ensure that those children and families most in need receive a timely service, including:
 - additional system developments, such as a framework for services, speech therapy focused coordination mechanisms, additional referral protocols, the sharing and analysis of common information and the use of broad mechanisms such as Primary Care Partnerships
 - demand management strategies to ensure those most in need are finding available services, that referrals are as efficient as possible and families receive reasonable assistance while awaiting services
 - supply strategies, including ensuring that assessment and service delivery models are as efficient and effective as possible, more consistent service provision by Community Health Services and measurement of service quality.

Appendix 2: Community Health Service catchment maps



Appendix 2: Community Health Service catchment maps

Map 2
Department of Human Services
Eastern Metropolitan Region
The catchments of Community Health Program-funded
paediatric speech pathology services, 2004



Appendix 3: Results of EMR Discussion Paper Forum on 8 June 2004

The following people were recorded as attending the forum:

Brenda Armstrong, Maroondah M&CHS
 Steve Ballard, Department of Human Services
 Graeme Bailey, MonashLink CHS
 Judy Baird, Maroondah CSRDO
 Miralde Bartlett, Manningham M&CHS
 Robyn Bishop, Warooga ECIS
 Ingrid Burt, Department of Human Services
 Anne Chapman, Knox CSRDO
 Kerryn Davis, Department of Human Services, SCS
 Sue Debney, MonashLink CHS
 Manique deSilva, Department of Human Services, SCS
 Shalon De Zilwa, Department of Human Services
 Annabel Evans, the Patch ECIS
 Cate Harris, Department of Human Services
 Jeff Herd, Department of Human Services
 Wilma Hills, City of Monash
 Kathy Hope, Department of Human Services
 Teresa Iacono, CRC
 Therese Kelly, Taralye ECIS
 Jo Kitching, Yarra Ranges PSFO
 Jann Kirkland, Department of Human Services, SCS
 Clare McGlone, MonashLink CHS
 Sue McCooey, EACH
 Sandy Mackevicius, RVIB ECIS
 Sue Matthews, Shire of Yarra Ranges
 Christine Miller, MonashLink CHS
 Anne Morgan, Illoura ECIS
 Gillian O'Lesky, Department of Human Services
 Fiona Page, Maroondah Hospital/Eastern Health
 Kate Paterson, Department of Human Services
 Jo Pertile, Maroondah Hospital
 Gayle Porter, Cerebral Palsy Education Centre
 Sonia Prescott, Whitehorse CHS
 Sharon Pretty, EACH
 Ros Pruden, Ranges CHS
 Joan Quigiana, Knox PSFO
 Kathy Robb, Department of Human Services
 Peter Ruzyla, EACH
 Katy Salmon, Whitehorse CHS
 Jeff Scoble, Knox CHS
 Jane Toop, Monash CSRDO
 Linda West, Ranges CHS

Participants at the forum were asked to indicate priority on a scale of 0 to 5 of 17 options for future action outlined in the Discussion Paper. The results were aggregated and options in rank order of priority appear below. While no option was deemed a low priority (the lowest was deemed a medium priority on average), particular options were deemed high priorities.

	Option	Score	
Option 1	Increase paediatric speech pathology in local CHS in the medium term.	0.95	5 average
13	Ensure access for children with feeding and swallowing disorders.	0.88	
4	Increase paediatric speech pathology in Specialist Children's Services in the medium term.	0.84	
2	Create paediatric allied health teams in local CHS in the medium term.	0.82	
15	Organise information and support while waiting.	0.81	
17	Clarify appropriate role in doing speech pathology assessments for school.	0.80	4 average
9	Services to explore common referral developments	0.78	
14	Work on criteria for priority access.	0.78	
16	Examine existing referral more closely and develop further strategies	0.75	
10	All CHS and SCS to separate initial assessment from therapy	0.74	
3	Cover Upwey area through Maroondah Hospital.	0.74	
5d	Supporting a regional network/ongoing training and development program.	0.72	
7	Address recruitment issue/explore shared positions.	0.72	
8	Improved communication about roles and referrals	0.72	
11	CHS to adopt targets for initial assessment and therapy.	0.72	
6	Improve speech and language info and training to generic service partners.	0.71	
12	SCS adopt targets for initial assessment and therapy.	0.69	
5b	Resource communication aid development.	0.66	
5a	Resource mentors in specialised areas	0.64	
5c	Resource a senior clinician leadership role.	0.59	3 average

Tables of participants were asked to indicate the top messages arising out of their discussions about options and priorities.

These messages have been grouped under headings:

	Prevention/ generic services	Funding/policy	Collaborative work on the service system	System focus	Recruitment
Table 1			Resourcing speech pathologists/senior clinician option/clarifying referral pathways.	Early identification and intervention 2-4 year-olds	
Table 2		Improving access which then assists to address demand through assessment, referral and early identification especially 2-3 yr-olds. Equity across EMR in relation to CHS, including Upwey.	Address service system issues by developing common assessment tools to assist practice and especially manage demand.		Recruitment
Table 3	Local network groups	More funding, and develop guidelines.	Discuss priority setting	Target young children 0-4 and do more thoroughly.	
Table 4	Prevention – universal programs	Pedagogy – use undergraduates to influence policy.	Prioritisation – role clarity for referral.		
Table 5		Support growth funding in SCS and CHSs.	Resource regional group of speech pathologists plus others – do best practice research, system and practice change to increase efficiency of resource use – are we working the best we can?		

Appendix 4: Bibliography

Australian Labor Party *Children First Labor's plan to give our children the best start in life 2002* (available at www.vic.alp.org.au/policy/children_first.html)

Department of Human Services *Best Start Effective Intervention Programs 2001* (available at www.beststart.vic.gov.au)

Department of Human Services *Best Start Evidence Base Project 2001* (available at www.beststart.vic.gov.au)

Centre for Community Child Health *Universal language promotion in the primary care setting 2002* (unpublished).

Commonwealth Task Force on Child Development, Health and Wellbeing *Consultation paper towards the development of a national agenda for early childhood 2004* (available at www.facs.gov.au/early_childhood)

Department of Education and Training *Program for students with disabilities 2004* (three handbooks) (available at www.sofweb.vic.edu.au/wellbeing/disabil/index.htm)

Department of Human Services *Communication, language and play: a universal language promotion strategy for 0-5 year olds 2004* (available at www.thedepartment.vic.gov.au/commcare)

Department of Human Services 'Defining a regional framework for speech pathology services in the Northern Metropolitan Region Final Draft' July 2002 (unpublished).

Department of Human Services *Early Childhood Intervention Services vision and key priorities 2003* (available at www.ecis.vic.gov.au)

Department of Human Services *Future directions for the Victorian Maternal and Child Health Service 2004* (available at www.the_department.vic.gov.au/commcare)

New South Wales Health Department *Better practice guidelines for managing speech pathology non admitted episodes of care 1999* (available from www.health.nsw.gov.au)

People Care Australia for the Department of Human Services 'Speech and language services in the Northern Metropolitan Region, Final draft' September 2000 (unpublished).

Reilly, S, Douglas, J., Oates, J (eds.) *Evidence-based practice in speech pathology 2004*

Sure Start Unit, British Government *Sure Start - promoting speech and language development- guidance for Sure Start programmes, 2001* (available at www.surestart.gov.uk/_doc/0-030731.pdf)

Syrmis, M.S., Keating, D.P., Hamilton, L.J., McMahon, S.M., *A best practice model for maximising access to paediatric speech pathology services Ambulatory Care Reform Program 1997*

